Incarcerated giant hiatal hernia

An 89-year-old man with valvular heart disease and third-degree atrioventricular block with a permanent pacemaker presented with a 1-day history of nausea, coffee ground emesis, and dyspnea. Physical examination revealed hyperthermia of 37.8 °C, oxygen saturation measured by pulse oximetry of 94 %, and hemodynamic stability. Laboratory tests showed a hemoglobin level of 13.9 g/dL, leucocytosis of 13 640/mm³ with neutrophilia, and a C-reactive protein level of 3.8 mg/L. A chest radiograph showed a giant hiatal hernia with migration of the entire stomach with an air-fluid level in an 89-year-old man with valvular heart disease and third-degree atrioventricular block.

Fig. 1 Chest radiograph showing a giant hiatal hernia with an air-fluid level in an 89-year-old man with valvular heart disease and third-degree atrioventricular block.

Fig. 2 Endoscopic image of the proximal stomach showing a large longitudinal ulcer, a congestive and dark-red surrounding mucosa suggesting gastric ischemia and gastric stasis.

Giant hiatal hernia represents 5–10 % of all hiatal hernias and includes at least 30 % of the stomach in the chest [1, 2]. Most frequently, a giant hiatal hernia is a mixed hernia composed of a sliding and a paraesophageal component [2]. Patients generally present with pain, heartburn, regurgitation, dysphagia, cough, dyspnea, vomiting, and anemia [2, 3]. The incidence of incarceration and strangulation is low [2]. Usually, in symptomatic patients, the definitive management is surgical repair [4]. Furthermore, owing to the risk of hemorrhage, strangulation, volvulus, and perforation in paraesophageal and mixed hernias, elective repair is recommended [5].

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Fig. 5 Laparoscopic view showing closure of the crural defect after reduction of the stomach into the abdominal cavity and complete excision of the hernia sac from the mediastinum.

Fig. 6 Laparoscopic view depicting the final result after gastric hernia reduction and the fundoplication.

References
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